

tackled this issue head on and created an interagency task force on the underground economy and employee misclassification. The purpose of the task force is to gather information and assess current enforcement resources in an effort to improve current enforcement methods.

The Federal Government needs to follow the lead of the States by addressing the current safe harbor. The determination of whether an employer-employee relationship exists for federal tax purposes is made under a common-law test that has been incorporated into specific provisions of the Internal Revenue Code or is required to be used pursuant to Treasury regulations.

In 1987, based on an examination of cases and rulings, the Internal Revenue Service developed a list of 20 factors for determining whether an employer-employee relationship exists. The IRS recognizes that there may be relevant factors in addition to the 20 factors. Most recently, the IRS has structured its inquiry into three groupings: behavioral control, financial control, and the relationship of the worker and firm.

Section 530 of the Revenue Act of 1978 generally allows taxpayers to treat a worker as not being an employee for employment tax purposes, regardless of the worker's actual status under the common law test, unless the taxpayer has no reasonable basis for such treatment or fails to meet certain requirements. Section 530 is commonly referred to as a "safe harbor." This provision was initially enacted for a year to give Congress time to resolve these complex issues. In 1982, the safe harbor provision was made permanent.

The Taxpayer Responsibility, Accountability and Consistency Act of 2009 would address the current loophole by requiring information reporting and making changes to the safe harbor. It would require businesses that pay any amount greater than \$600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS. A similar provision has been proposed by both Presidents Obama and Bush. This provision will ensure that contractor income is accurately reported in order to prevent fraudulent underpayment of taxes.

The Taxpayer Responsibility, Accountability and Consistency Act of 2009 revises the safe harbor and makes it part of the Internal Revenue Code of 1986. The safe harbor would continue to be available to employers for purposes of shielding them from liability, but it will be narrowed to reduce abuses and to ensure they had a genuinely reasonable basis for not treating such individual as an employee. Under the Taxpayer Responsibility, Accountability and Consistency Act of 2009, an employer shall be treated as having a reasonable basis for treating an individual as an independent contractor only if the decision was based on a written determination by the IRS to the taxpayer addressing the employment status of

such individual or another individual holding a substantially similar position with the taxpayer, or a concluded employment tax examination by the IRS.

The current safe harbor would continue to apply to services rendered up to one year after the date of enactment; after that, the new safe harbor would apply to services rendered more than one year after the date of enactment.

I urge my colleagues to cosponsor the Taxpayer Responsibility, Accountability and Consistency Act of 2009 which will provide valuable protections to workers who are erroneously misclassified and help combat the underground economy.

#### AMENDMENTS SUBMITTED AND PROPOSED

SA 3219. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3220. Mr. RISCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3221. Mr. WYDEN (for himself and Mr. DURBIN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3222. Mr. FEINGOLD submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3223. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3224. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3225. Mr. LEMIEUX submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3226. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3227. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3228. Ms. LANDRIEU (for herself, Mr. WARNER, and Mr. AKAKA) submitted an

amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3229. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3230. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3231. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3232. Mr. BYRD submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3233. Mr. BYRD submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3234. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3235. Mr. CASEY (for himself and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3236. Mr. KOHL submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3237. Mr. BURRIS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3238. Mr. ROCKEFELLER (for himself, Mr. KOHL, Mr. CARPER, and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3239. Mr. ROCKEFELLER (for himself, Ms. COLLINS, and Mr. KOHL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3240. Mr. ROCKEFELLER (for himself, Mr. LIEBERMAN, Mr. WHITEHOUSE, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3241. Mr. CARPER (for himself, Mr. CONRAD, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

## TEXT OF AMENDMENTS

**SA 3219.** Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 396, between lines 8 and 9, insert the following:

**Subtitle H—Patient Protections****PART I—IMPROVING MANAGED CARE****Subpart A—Utilization Review; Claims****SEC. 1601. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.**

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not later than 5 days after the date on which the request for information is received

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such re-

quest) shall be treated as the making at that time of a claim for such benefits without regard to whether and when a written confirmation of such request is made.

(b) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination.

(c) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (b) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination); and

(2) the procedures for obtaining additional information concerning the determination.

(d) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The term “authorized representative” means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual's consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term “claim for benefits” means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term “denial” means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this part.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term “treating health care professional” means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

**Subpart B—Access to Care****SEC. 1611. CHOICE OF HEALTH CARE PROFESSIONAL.**

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of

participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

**SEC. 1612. ACCESS TO EMERGENCY CARE.**

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term “emergency services” means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must